

Special Commission on the Health Care Payment System
Commission Meeting Minutes
February 6, 2009

Meeting Date, Time, and Location

Date: Friday, February 6, 2009

Time: 12:00 p.m. – 3:00 p.m.

Place: Gardner Auditorium, State House Boston, MA 02108

Meeting Attendees

Commission Members	Speakers	Contractors
✓ Leslie Kirwan (co-chair)	✓ JudyAnn Bigby, MD	✓ Michael Bailit, Bailit Health Purchasing
✓ Sarah Iselin (co-chair)	✓ Lucian Leape, MD	✓ Bob Schmitz, Mathematica Policy Research, Inc.
✓ Alice Coombs, MD	✓ Alan Sagar	✓ Margaret Houy, Bailit Health Purchasing, LLC
✓ Andrew Dreyfus	✓ David Matteodo	
✓ Deborah C. Enos	✓ Ellen Murphy Meehan	
✓ Nancy Kane	✓ Marylou Buyse, MD	
✓ Dolores Mitchell	✓ Rick Weisblatt, MD	
✓ Richard T. Moore	✓ Marc Spooner	
✓ Lynn Nicholas	✓ Antonia Blin	
	✓ Gerry Steinberg, MD	
	✓ Brian Rossman	

Meeting Minutes

Co-Chair Kirwan summarized the importance of the Payment Commission's work by reminding attendees that to sustain universal health insurance coverage health care costs must be contained. The Commission will be developing both short-term and longer-term implementation strategies. She welcomed input from all stakeholders and that obtaining input was an important part of the Commission's responsibilities.

Co-Chair Iselin explained the process for today's meeting, which is dedicated to receiving input from stakeholders. Those who had not signed up in advance were invited to speak. All speakers were asked to limit remarks to 5 minutes. All written comments will be shared with the Commissioners and will be read. After each speaker's presentation, Commissioners will be offered an opportunity to ask questions. The Commission will receive written presentations until February 11. Attendees were advised to go to the Payment Commission's website for instructions.

1. JudyAnn Bigby, MD, Secretary of the Executive Office of Health and Human Services

Following are the key points made by Secretary Bigby:

- The Commission has an opportunity to think big to reach the Commonwealth's goals of improving cost, quality and equity.
- Consider an all-payer system that has the same payment rates and methodology for all providers. This includes higher payments for Medicaid to avoid cost shifting.

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- Protect safety net providers by giving them additional payments.
- Include public and private payers collaboratively.
- Use an episode of care payment system for providers, adjusted for case complexity. Provide additional payments to teaching hospitals to cover teaching costs.
- Build in accountability for care over time, which is associated with higher quality and lower costs.
- Increase payments to PCPs to recognize the value of preventive services. Pay for services not historically reimbursed, including care coordination. Reward providers for providing patient-centered care.
- Have a fully vertically and horizontally integrated system with the patient having multiple connecting points.
- Promote coordination across delivery groups.
- Include Computerized Order Entry Systems with full interoperability.

Commissioner's Questions

The following summarizes the Commissioners' questions and the speaker's responses:

Question	Response
How can we get to a virtually integrated system of providers starting from where we are now (with lots physician practices of 1s and 2s)?	Possibly create a regional coordination center that would provide the type of support available in larger group practices. Groups could share back office and other systems.
Should case mix adjustments be made pre-service or at the end of the year?	Either might be acceptable.
How should we deal with providers who will not take certain types of insurance or will only take cash? What about concierge practices?	This is a question of how much tolerance there should be in the redesign for individual decisions. Rates should be more equal so that there is no reason not to accept Medicaid
If there is a state authority with oversight responsibilities, do you envision a work-around for Medicare or every payer using the same song book?	I am thinking about a CMS waiver.
Do you see the PCP as gatekeeper in a positive way to achieve a patient-centered approach?	PCPs must support and advocate for the patient. The key is an episode of care payment, which would require providers to work in integrated systems.
What ideas do you have to restrain the growth of high fixed cost technologies which create volume incentives?	We would need to evaluate what is needed regarding health planning, including comparative effectiveness evaluation.
Do we have enough resources in the system to fund the changes you are discussing?	We currently have enough resources to make an orderly transition. Interim steps to strengthen primary care, and provide P4P incentive systems on top of the current FFS system have had mixed results. We need to look at a whole system redesign.

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2. Lucian Leape, MD, member of the Harvard Medical School Faculty, speaking as an individual

Following are the key points made by Dr. Leape:

- It is not enough to bend the curve; health care costs must be reduced.
- Overuse and under use are the two causes for increased health care costs.
- The answer is to work in teams. Pay for care in an integrated way by doing the following:
 - i. Pay for care not for services
 - ii. Pay for groups of providers, not individuals. PCPs, specialists, social workers, etc. must work together to provide better care for individuals.

Commissioner's Questions

The following summarizes the Commissioners' questions and the speaker's responses:

Question	Response
How would you account for differences in the quality of provider practices in a payment system?	Hold groups accountable for outcomes. Leave it to the group to figure out how to get to outcomes. Physicians are able to get together, figure out how to get quality care and to police themselves.
What innovations would you suggest to bring small practices of 1 and 2 physicians into a group mode?	EMR is one way to link people to a common set of standards and practices. Doctors must be told that they must come together and work as a team.
What structure would you suggest to change the current culture and stop the introduction of new technology, even before its value is proven?	Establish a federal board to assess the cost and effectiveness of new technologies. We need to make decisions regarding what works and only pay for what works.
Sometimes people working in teams, not the payment system, results in better decisions, including reviewing cases retrospectively to learn from different situations.	I agree.

3. Alan Sager, Professor, Health Policy and Management, Boston University

Following are the key points made by Professor Sager:

- There is enough money in the system to provide quality health care services for everyone.
- Massachusetts spends 1/3rd more per person (\$11,100) than the national average.
- All efforts to date have not controlled health care costs. Containing costs is a retail job requiring the active, motivated involvement of enthusiastic physicians.
- Recommendations: promote the medical home concept, eliminate defensive medicine, eliminate unnecessary paperwork, create a full frontal capitation of \$8000 per person, risk adjusted. Put the funds into three water-tight buckets for primary care, specialty care and all other care.

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Commissioner's Questions

The following summarizes the Commissioners' questions and the speaker's responses:

Question	Response
Please explain the \$700 million.	There are about 6.4M people in Massachusetts. If we want the patient panel of each primary-care physician to be 1,000 on average, then we require 6,400 primary-care physicians. If the average pay of a primary-care physician is \$110,000, then the total annual payment for these physicians is about \$700 million.
Were hospitalists included in your calculations?	They were not included.
How can you change the dynamic of medical students not going into primary care because of prestige and other less tangible issues?	There is a need to recognize the difficulty of the job and the variety of strengths required to do it well to increase the prestige of this area of practice.
What is your reform suggestion?	Bundled payments, a governmental entity to evaluate effectiveness of technology and services, but a voluntary system to measure outcomes.
How are PCP's salaries increased?	Adopt a medical home model with capitated payments in the amount of \$8000 per person, risk adjusted. Then divide funds into three water-tight buckets – PCP services, specialty services, pharmacy and everything else. Dental care and OTC drugs are not included. Physicians can decide how they want to be paid. I want doctors to concentrate less on their own incomes and more on what they can control.
How do you define self-regulation? Seems to me that government must set standards of performance.	There must be a mixture. Initially physicians would volunteer and do what is best for the patient by practicing evidence-based medicine. We would learn from their experience. Regulations could track adherence to EB standards and horizontal equity (patients being treated the same).
Are hospitals covered by the \$8000 capitation?	Pay hospitals on a prospective basis. Physician groups would buy hospital care to mimic the free market.
In England there are 75% PCP and 25% specialists, which is the opposite from the US. How can we get there?	No answer.

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4. David Matteodo, Massachusetts Association of Behavioral Health Systems

The following are the key points made by Mr. Matteodo:

- Inpatient mental health and substance abuse facilities are a small but significant part of the health care system. 75% of income is from a public payer.
- We need a payment system with the following characteristics:
 - Predicable and understandable.
 - Incentives are aligned with good patient care. Currently there are increasing pressures for short lengths of stay. We want to give patients what they need.
 - Appropriate oversight for treating clinicians. Currently authorizations from MCOs take hours. Once the patient is admitted there is continuing second-guessing by MCOs.
 - Increase deeming opportunities with respect to credentialing organizations.
 - No additional unfunded mandates. Additional requirements must come with additional funding in this fiscal crisis.
 - State agency requirements must be taken into consideration. Currently DMR and DCF agencies have administrative days. The children get stuck because of no appropriate placements; we receive a reduced payment, but the child continues to get the same level of care. This in turn keeps kids in the ER, instead of inpatient placement. These problems may increase with state hospitals closing.
 - Be sensitive to fixed costs and on-going costs. In FY09 there was no MassHealth rate increase, but our costs are continuing to increase.

Commissioner's Questions

The following summarizes the Commissioners' questions and the speaker's responses:

Question	Response
Which payment system would be best for behavioral health services, and to encourage integration of behavioral and all other health services?	Behavioral health must be integrated into incentives. Often a PCP doesn't know that a patient is in a psych hospital. A payment system must support stronger inter-relationships.
The current system does not recognize the complexity of these patients, particularly in the ER.	The most important thing is to change the situation in the ER. ER waits for an inpatient bed should be limited to 24 hours. We need quicker authorizations.

5. Ellen Murphy Meehan, Alliance of Massachusetts Safety Net Hospitals

Following are the key points made by Ms. Meehan:

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- Low-income patients rely on safety net hospitals. These hospitals are paid less. The quality of care is different. Access to capital and the physical plants are unequal. Access to specialists is unequal. They also provide additional unreimbursed services, including translation, and social services.
- We try to grow PCP practices, but it is hard to compete with other facilities receiving higher payments.
- We are concerned that we will be left behind in payment reform.
- We had hoped that under health care reform we would have received more dollars. They went to the teaching hospitals because of the criteria used. We have seen our rates decline through health care reform. We provide much more outpatient care to uninsured people than do teaching hospitals.
- A 25% add-on has been endorsed to remedy the problem. We would like this to remain. Payment reform must consider these hospitals. Flexibility is needed to save these hospitals. Payments must cover costs.
- These hospitals do not have access to low-cost capital to buy EMRs.
- These hospitals do not have control over the largest physician practices in the area, because they are attached to tertiary hospitals.
- A new payment system must have the following features:
 - i. The cost of care is covered by the payment levels.
 - ii. It must adapt to the type of patients served.
 - iii. It does not perpetuate inequities that exist today.

Commissioner's Questions

The following summarizes the Commissioners' questions and the speaker's responses:

Question	Response
What type of payment system would be best for your hospitals?	A system that creates a level playing field in the short run.
In the long run would an all payer system with the same level of payment work for your hospitals?	The same level of payments won't work. We have no EMRs; our facilities are old. We need extra dollars to get even.
Why do lower income patients go to DISH hospitals when other hospitals are available?	These hospitals understand this population and serve them well. Serving them is part of their mission. Others don't want to care for people who pay them less.
Is the problem one of poor distribution? Is there enough money in the system to provide the necessary care for everyone?	I cannot answer this question. I ask the Commission to look into hospitals spending money to move into well-to-do suburbs and whether the dollars could be used better. Possibly incentives could be provided to hospital workers to receive the care at the hospital where they work.

6. Marylou Buyse, MD, Massachusetts Association of Health Plans

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The following are the key points made by Dr. Buyse:

- Keeping health care costs affordable is challenging to all.
- All can benefit from reforming the health care system, leading to better coordination of care and improved quality.
- Reform should recognize:
 - Cost control should result in lower costs for consumers and payers.
 - One size does not fit all.
 - It takes time to implement reform and requires interim steps. Most providers are not in positions to implement needed change.

No questions were asked of Dr. Buyse.

7. **Rick Weisblatt, MD**, Medical Director for Behavioral Health and Pharmacy, Harvard Pilgrim

Following are the key points made by Dr. Weisblatt.

- Tufts Health Plan has 80% of its PCPs either under risk contracts or eligible to receive P4P payments, which represents 80% of our members.
- 18 months ago we included hospitals in our P4P program.
- We have incentives regarding infrastructure, quality and efficiency.
- We have seen improvements in all domains (citing statistics over a 2 or 3 year time period).
- The keys to a successful P4P program include:
 - A long-term strategy to engage leadership, provide practice support and use nationally accepted measures. Physicians can be well organized in small practices with 1 or 2 physicians.
 - If all payers used the same measures, it would have an impact.
- Some of the issues that must be addressed.
 - We are just starting with efficiency measures, and are just at the tip of the iceberg.
 - There are few specialists' measures.
 - P4P does not change FFS incentives.
 - P4P is not applicable to PPO and self-insured accounts.

Commissioner's Questions

The following summarizes the Commissioners' questions and the speaker's responses:

Question	Response
What percent of total payments are P4P incentives?	Between 5 to 10%.
We need to share information to get a bigger penetration and make a bigger impact on a physician's practice.	With enabling infrastructure, we would be happy to participate. You must have Medicare as a player. Without them 50% of a physician's practice is off the table.
Do you see a need to move away from a FFS model to get at delivery issues and bring about	Yes. Physician group should be able to tell plans what payment methodology they want.

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Question	Response
reform?	We need options for smaller groups. Risk adjustments are needed.
MassHealth is the payer that is most unlike other payers.	When we went to hospital P4P, we used CMS measures and reports. CMS can drive change.
What are the three lessons learned that you can share?	<ol style="list-style-type: none"> 1. All parties must be engaged in the beginning. Use a collaborative model. 2. Leadership and infrastructure within practices are key to bringing about practice pattern changes. 3. All payers must be involved and using the same methodology and approach to payment.
How should we pay for big-ticket items such as use of ICU at end of life situation?	P4P needs to be based on consensus. There is no consensus regarding end of life. P4P must be easy to implement. There is no precedent regarding an end of life case. Reform of practice of medicine must come from medical practitioners.
Do you think that episode of care payments might bring about the behavioral change we are looking for?	It depends on who is involved in the capitated group. A PCP under capitation could not impact behavioral of oncologists. Maybe prospective payments would be better. This is why we need a range of approaches to bring in hospitals and specialists.

8. Marc Spooner, VP of Provider Contracting at Tufts Health Plan

Following are the key points made by Mr. Spooner:

- Tufts Health Plan has extensive experience with capitation in its Medicare Advantage product.
- Capitation has been criticized for inappropriately rewarding under utilization. Our experience is that this is mitigated by use of disease management programs.
- Providers who are willing to take on a risk-based contract have infrastructure to control referrals, and they must be willing to manage care by engaging patients in difficult conversations.
- Tufts Health Plan provides support to providers by sharing best practices and analyses of practice patterns.
- For capitation to work in a commercial environment, there are three determinative factors:
 - i. Whether the provider has capital and the infrastructure to manage care.
 - ii. Whether a sufficient scope of services are provided at the home hospitals using local specialists.
 - iii. Whether there is a sufficient degree of integration between the physicians and the home hospitals. There need to be conversations about sharing financial risk with the hospital.
- View capitation as an option, not a panacea.

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Commissioner's Questions

The following summarizes the Commissioners' questions and the speaker's responses:

Question	Response
How can we change the cultural issues around patient expectations?	Patients are used to easy referrals. It is time to open conversations with patients.

Dr. Buyse offered to share with the Commission a paper on cultural issues regarding Americans and health care.

9. Antonia Blin, Massachusetts Association of School-Based Health Centers

Following are the key points made by Ms. Blin:

- 25 different organizations coordinate to provide services in 62 different centers.
- A variety of organizations would be impacted by reimbursement changes.
- School-based health centers are convenient, cost effective. They are run by nurse practitioners.
- Prior authorizations are barriers to the Centers receiving necessary financial support. Easy referrals should be available when services are provided in a confidential way to high-risk young men and women.

Commissioner's Questions

The following summarizes the Commissioners' questions and the speaker's responses:

Question	Response
What key message do you want the Commission to hear?	Do not forget about us as part of the health care system. We can play a bigger role in providing cost-effective, high quality care. Students are getting care when and where they need it.

10. Jerry Steinberg, MD, Chief Medical Officer and Quality Officer at Cambridge Health Alliance

Following are the key points made by Dr. Steinberg:

- CHA is a DISH hospital and we care for a large number of patients with behavioral health issues. We have seen an increase of 80,000 visits.
- Payment reform must address the disparity in reimbursement across provider types and services. Payments for behavioral health services do not cover costs, and there is a need to level the playing field.

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- Payment reform must be a primary care based system that promotes cost effective, high quality services.
- Reforms must promote stronger team-based primary care with mental health and shared responsibilities.
- We must transition from volume to value.
- We must align financial incentives with the goals of promoting prevention, optimal utilization, wellness and best outcomes.
- Optimal utilization must reside within the work of providers. It cannot be based on authorizations.
- There must be enhanced payments for primary care, chronic care management, mental health and substance abuse services.
- CHA has had experience with team-based models for management of chronic diseases with positive results. Currently care coordination, improved access, group visits, and outreach to hard-to-reach patients are not reimbursable service.
- CHA has some needed infrastructure to manage care. We are interested in being a demonstration partner.
- Graduate Medical Education payments should be directed towards primary care. We also need post graduation support. Payments need to be focused on outpatient educational services.

Commissioner's Questions

The following summarizes the Commissioners' questions and the speaker's responses:

Question	Response
Why do insurance rates continue to increase, and why does hospital bad debt not decline with more people insured and payment for care received?	Lots of work needs to be done on the provider side to meet the goals set out.

11. Brian Rossman, Health Care For All

Following are the key points made by Mr. Rossman:

Health reform must have the following characteristics:

- Be like Snow White – be transparent. Payment must be transparent and open so patients can see the incentives for providers and plans.
- Be like Dumbo – recognize patient empowerment. We need to be aware that the patient needs to be more involved. There need to be decision-making aids so that patients can understand their options, and chronic disease self-management skill development.
- Be like Goldilocks – it needs to get the size right. It needs to use validated methodologies for risk adjustments.
- Be like Little Red Riding Hood – recognize the role of public health in payment reform. Some areas, such as translation services, might not be appropriate for payment reform, and should be paid with public health dollars.

No questions were asked of Mr. Rossman.

The session ended at 3:10pm.